DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4730 (Rev. 11/01)

STATE OF WISCONSIN
ss. 255.06, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP)
EXPANDED SERVICE ACTIVITY REPORT - ARF

Information and Instructions on reverse side.

PERSONAL INFORMATION

1. Last Name	2. First Name	3. Middle Initial
4. Maiden Name	5. Date of birth (mm/dd/yyyy)	6. County

7. Social Security Number (Optional) or Client Identification Number

SCREENING INFORMATION

Screening Categories	Initial Screening Results	Additional Services Recommended
Hypertension Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Risk factors present? ☐ Yes ☐ No ☐ BP screening (annual) - CPT Code 99211 Within normal limits? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No ☐ BP Follow up visit / up to 2 x per yr - CPT Code 99211 Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	
Dyslipidemia Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Risk factors present? ☐ Yes ☐ No ☐ Lipid panel (annual or abnormal follow up) - CPT Code 80061 Within normal limits / goal? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No ☐ Lipid panel (in 6 months) - CPT Code 80061 Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	
Diabetes Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Risk factors present? ☐ Yes ☐ No ☐ Glucose, fasting (every 3 years >age 45 or annual if risk factors present) - CPT Code 82947 Within normal limits? ☐ Yes ☐ No ☐ Glucose, random (every 3 years >age 45 or annual if risk factors present) - CPT Code 82947 Within normal limits? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No ☐ Repeat fasting glucose - CPT Code 82947 ☐ Glucose tolerance test - CPT Code 82951 Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	
Osteoporosis Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Risk factors present? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	
Depression Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Screened? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No ☐ Psychiatric diagnostic interview - CPT Code 90801 Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	
Domestic Abuse Date performed: _____/_____/_____ (mm) (dd) (yyyy)	Screened? ☐ Yes ☐ No Information given? ☐ Yes ☐ No	Follow up needed? ☐ Yes ☐ No Other recommendations? (Not covered by WWWP) ☐ Yes ☐ No
*Provider Number	Provider Name and Location	

Additional notes or recommendations:

Send the completed top copy of form to: WWWP, P. O. Box 6645, Madison, WI 53716-0645

White (Top) Copy– WWWP Yellow (2nd) Copy – Provider Pink (3rd) Copy – WWWP Local Coordinating Agency

INFORMATION AND INSTRUCTIONS FOR
WISCONSIN WELL WOMAN PROGRAM (WWWP)
EXPANDED SERVICES ACTIVITY REPORT – ARF**

In accordance with Wisconsin State Statutes, ss. 146.82(1), Confidentiality of patient health care records, all patient records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PRINT CLEARLY

PERSONAL INFORMATION

1. Print client's Last Name.
2. Print client's First Name.
3. Print client's Middle Initial.
4. Print client's Maiden Name, if applicable.
5. Indicate client's Date of Birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate county in which client resides.
7. Indicate client's Social Security Number (optional) or Client Identification Number (CIN). The Local Coordinating Agency assigns and will provide the CIN.

Screening Categories	Initial Screening Results	Additional Services Recommended
For each screening indicate date performed. Use numbers for month, day and year, (i.e. 01/01/2001)	Reference WWWP Manual for Risk Factors. (Reference WWWP Manual for reimbursable procedures and CPT codes) Check appropriate box for result.	Check if additional follow-up is recommended. Check appropriate box for additional service(s) recommended for follow-up. (Reference WWWP Manual for reimbursable procedures and CPT codes) Other recommendations are not covered by WWWP.
*Indicate the provider number	Indicate provider name and city where provider is located or the name and city of Clinic providing screening(s).	
Document additional notes or recommendations in space provided at the bottom of the form.		

***If there are different providers responsible, please list provider information for each service provided.**
****Activity Report Form**

Send the completed top copy of form to:
WWWP
P.O. Box 6645
Madison, WI 53716-0645